

DIVISION USE ONLY

HEALTH

Rx

DENTAL

VISION

Location #Term (mos)

1. APPLICANT INFORMATION

Social Security Number--

Last Name

Title (Jr/Sr/etc)

First NameMIStreet Address (Include Apartment #)CityStateZip Code + 4Date of Birth (mm/dd/yyyy)Gender (M/F)Relationship to EmployeeMarital Status (check one) - Single - Married - Divorced - Widowed - Area Code - Home Telephone Number

2. CHANGE INFORMATION (If applicable)

a. Type Open Enrollment Special Enrollment Status Change (complete 2b)

b. Moved Out of Coverage

Area (Date of Move)

Add Spouse

(Date of Marriage)

Date of Birth of Child

Adoption/Guardianship of Child (Proof required)

Date of Adoption/Guardianship

Other (specify)

3. EMPLOYEE INFORMATION (if different from applicant)

Social Security Number--

Last Name

First Name

Date of Birth (mm,dd,yyyy)

4. COVERAGE ELECTION - Select the coverage desired and indicate with an X in the appropriate box

TYPE OF COVERAGE	SINGLE	MEMBER & SPOUSE	FAMILY	PARENT & CHILD(REN)
Health: Traditional				
Health: NJ PLUS				
Health: HMO				
Dental Indemnity				
Dental Plan Organization (DPO)				
State Prescription Drug Program				
Vision Care				

5. HEALTH PROVIDER INFORMATION

(a) Name of HMO

(b) Your NJ PLUS or HMO Doctor ID#

(c) Name of DPO

(d) Your DPO Dental Provider Name and Address

6. SPOUSE AND DEPENDENT INFORMATION — List all dependents you wish enrolled for coverage. Use a separate page for additional dependents.

Spouse: Last Name

First Name

Date of Birth (mm,dd,yyyy)

Gender

Social Security Number——

*Dependent's HMO doctor, Health Center or NJ PLUS doctor ID #

Natural (C)
Adopted (A)
Foster (F)
Stepchild (S)

Dependent(s)

7. ☐ **SSA DISABILITY EXTENSION** — Check this block if you have an approved Social Security Administration Disability and wish your COBRA term extended to up to 29 months. Attach a copy of the Social Security Administration Disability approval letter.

8. I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health plan or become entitled to Medicare after I elect coverage under COBRA. I understand that my coverage under COBRA will be continuous from the date the employer stopped providing it and that I will be required to pay for the amount due for back coverage. I agree to make future payments in a timely fashion. I understand this COBRA coverage will terminate without notice if payment is not made on time.

APPLICANT'S SIGNATURE _____ DATE _____

DO NOT SEND PAYMENT WITH APPLICATION - YOU WILL BE BILLED

— COBRA NOTICE —

CONTINUATION OF STATE HEALTH BENEFITS PROGRAM COVERAGE UNDER COBRA
STATE BIWEEKLY AND MONTHLY

This page is to be completed by Employer (Please print or type)

a. To the Family of —

c. Notice Date: _____

d. Employer Name: _____

e. EI # _____ f. EMPLOYEE TYPE:

☐ 10 month

☐ 12 month

b. SS#: _____

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you.); (3) you fail to pay your premiums in a timely manner; or (4) your employer drops out of the State Health Benefits Program.

If you are retiring, you may be eligible for lifetime health coverage in the Retired Group of the State Health Benefits Program. Consult your employer or the Division of Pensions and Benefits **PRIOR** to enrolling for health benefits under COBRA.

If you are not eligible for or do not wish to continue on the group plan under COBRA, you may be eligible for a conversion to a private, direct pay plan with your current insurance carrier. Consult your insurance carrier or your employer if you have questions.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P. O. Box 299, Trenton, NJ 08625-0299**. If you elect to continue coverage, you will be enrolled so you have no break in coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The SHBP will send you an invoice of premiums that are due for your coverage.

Instructions for completing the application and a rate chart are enclosed with this notice. You should make a copy of this notice and your completed application for your records prior to mailing the originals to the **Division of Pensions and Benefits**. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact our **SHBP Hotline** at (609) 777-4355 and leave your name, Social Security number and telephone number and a representative will return your call within two business days.

g. COBRA EVENT: (check one)

- ☐ Retirement
- ☐ Privatization
- ☐ Termination other than Retirement/Privatization
- ☐ Reduction in Hours
- ☐ Leave of Absence

— State/Federal Family Leave

— Other
- ☐ Death
- ☐ Divorce or Separation
- ☐ Dependent ineligibility — over age 23
- ☐ Dependent ineligibility — marriage
- ☐ Dependent ineligibility — moved out
- ☐ Medicare Entitlement

j. CURRENT COVERAGE TYPE: (Check one)

HEALTH PLAN			NON-CORE PLANS		
Traditional	HMO	NJ PLUS	Dental	Rx	Vision
() S	() S	() S	() S	() S	() S
() M&S	() M&S	() M&S	() M&S	() M&S	() M&S
() P&C	() P&C	() P&C	() P&C	() P&C	() P&C
() F	() F	() F	() F	() F	() F

HMO Plan _____

Dental Plan _____

h. DATE OF COBRA EVENT: _____

i. CONTINUATION TERM: _____ months of COBRA eligibility

k. LAST DATE OF COVERAGE (Month/Date/Year):

Health _____ Dental _____ Rx _____ Vision _____

l. EMPLOYER CONTACT AND TELEPHONE #: _____

m. _____
Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE
OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA.
FAILURE TO RESPOND WITHIN THIS TIME PERIOD
IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE